Legislative Council Staff
Nonpartisan Services for Colorado's Legislature

Room 029 State Capitol, Denver, CO 80203-1784
Phone: (303) 866-3521 • Fax: (303) 866-3855
lcs.ga@state.co.us • leg.colorado.gov/lcs

Memorandum

August 21, 2018

TO: Opioid and Other Substance Use Disorders Study Committee

FROM: Bill Zepernick, Principal Fiscal Analyst, 303-866-4777

SUBJECT: Summary of Stakeholder Policy Recommendations

Overview

This memorandum presents policy recommendations submitted by stakeholders and interested persons for consideration by the Opioid and Other Substance Use Disorders Interim Study Committee. The following section lists the recommendations submitted, grouped into several broad categories. The full recommendations submitted by stakeholders can be found starting on page 4 of this memorandum. Note: the text of the stakeholder recommendations have been formatted by Legislative Council Staff to improve readability, correct typographical errors, and remove personal contact information, but are otherwise presented in their original, unedited form.

Stakeholder Policy Recommendations

The lists of policy recommendations below were summarized and compiled by Legislative Council Staff based on stakeholder submissions. For more detail on each proposal, see the full response submitted by the individuals or organizations listed in parentheses.

Prevention and Screening

1) Update the Colorado Children's Code to align with federal Child Abuse Prevention & Treatment Act requirements related to substance exposed newborns (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)
2) Support policies to improve behavioral health services provided by caregivers (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)
3) Improve access and utilization of prenatal and maternal medical care and substance use disorder treatment (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones, Lauren Snyder)
4) Improve comprehensive assessments for substance use disorders (Alyson Williams)
5) Support home visitation programs (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)
6) Pilot behavioral health integration in obstetric practices (Ellen Stern)
7) Prenatal SBIRT pilot for prompt MAT (Qing Li)

Provider Practices and Licensing

1) Require all SUD providers and care coordination entity to use a standardized level of care criteria (for example, ASAM criteria) when determining level of care (Lauren Snyder)
2) Require continuing medical education on substance use disorders for all health professionals to renew their certifications or licenses in the state (Alyson Williams)
3) Incentivize psychiatrists to become board certified in addiction psychiatry (Alyson Williams)
4) Expansion of the authority to recommend marijuana to Advanced Practice Nurses and Physician's Assistants (Lisa Pearson)
5) Recognition of the American Board of Pain Medicine by the State of Colorado (Kenneth Finn)
6) Change professional licensing requirements for substance use treatment facilities (Angela Bonaguidi)

Treatment

1) Increase evidence-based withdrawal, treatment, and recovery capacity (Alyson Williams)
2) Increase access to and utilization of MAT and SUD treatment (Alyson Williams)
3) Allow crisis stabilization units to accept individuals who are in a mental health crisis but also have a substance "on-board" (Alyson Williams)
4) Consider a more comprehensive federal 1115 waiver with more time for the development of additional facets to address substance use disorders (Alyson Williams)
5) Facilitate access to prenatal care in MAT clinics (Ellen Stern)
6) Expanded investment in outpatient services, with particular attention towards intensive outpatient services (Lauren Snyder)
7) Eliminate barriers to treatment such as prior authorizations for opioid use disorder medications (Pauline Whelan)
8) Establish credible patient/provider linkages with a dedicated list of credentialed opioid use disorder providers; ensure network capacity is sufficient to meet the treatment gap (Pauline Whelan)
9) Expand and appropriately reimburse services in opiate treatment programs ("OTP" - methadone clinics) to include all forms of medication assisted treatment (Pauline Whelan)
10) Rate parity for SUD and mental health treatment services (Kristen Dixion, Angela Bonaguidi)

Treatment in Criminal Justice System

1) Increase access to and support continuation of MAT in jails (Lisa Raville, Alyson Williams, Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones, Pauline Whelan)
2) Support MAT for pregnant or postpartum women in in jails (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)
3) Pilot a fetal alcohol spectrum disorder screening and referral program within the juvenile justice system (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)

Harm Reduction

1) Syringe exchange out of emergency departments (Lisa Raville)
2) Public syringe disposals (Lisa Raville)
3) Increase access to naloxone for those within the correctional system (Alyson Williams)

Data and Coordination

1) Improve data collection, interoperability of data collection systems, and data sharing (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)
2) Create a care coordination entity or system that would determine the level of care independent of any particular provider (Lauren Snyder)
3) Create a comprehensive capacity tracking system for bed space and provider utilization (Lauren Snyder)

Other Recommendations

1) Local governments regulate sober living homes under state framework (Chris Coddington)
2) Expand child care options for parents accessing substance use disorder treatment and recovery services (Kathryn Wells, Jillian Adams, Dr. Pastora Garcia-Jones)
3) Marijuana as an alternative to opioids (NORML/various citizens)

Submitted Policy Recommendations

The following submissions were not included in the summary above due to time comstraints.

Recommendations from Lisa Raville, Harm Reduction Action Center

1) **Syringe Exchange out of Emergency Departments.*** There are 10 syringe exchange programs in the state of Colorado. For syringe exchange programs to operate, there must be county board of health approval. Unfortunately, many board of health folks are commissioners and elected in that position. Many elected officials are not comfortable with syringe exchange programs, even though they are heavily researched and best-practice evidence-based interventions. Colorado has black tar heroin and primarily injected. Hospitals need to be able to provide syringe access, proper syringe disposal, and the supplies needed to prevent and eliminate the transmission of HIV and viral hepatitis in our most vulnerable communities.

   *For example: SECTION 1. In Colorado Revised Statutes, 25-1-520, add (2.5)
   3 and (7) as follows:
   4 25-1-520. Clean syringe exchange programs - approval -
   5 reporting requirements. (2.5) A PROGRAM DEVELOPED PURSUANT TO
   6 THIS SECTION MAY BE OPERATED IN A HOSPITAL LICENSED OR CERTIFIED
   7 BY THE STATE DEPARTMENT PURSUANT TO SECTION 25-1.5-103 (1)(a).
   8 (7) AN INDIVIDUAL WHO PROVIDES A CLEAN SYRINGE IN
   9 ACCORDANCE WITH A CLEAN SYRINGE EXCHANGE PROGRAM ESTABLISHED
   10 UNDER THIS SECTION IS NOT LIABLE FOR ANY CIVIL DAMAGES RESULTING
   11 FROM THE ACT.

2) **Public syringe disposals.** Across the county, the numbers of people injecting drugs and other substances has risen dramatically over the last decade. Colorado is not immune to the challenges associated with the many layers of treatment, prevention, and harm reduction necessary to decrease the harms related to substance use. It is estimated that approximately 3 billion syringes, sharps, and lancets are disposed into municipal waste streams and recycling bins annually across the country. Communities are struggling to ensure the health and safety of children, sanitation workers, and the general public without effective disposal options for biohazardous material. Communities seek to address a number of factors responsible for improper disposal of used syringes in public areas. These public disposal containers will enhance the opportunity for the safe disposal of used sharps and reduce risk of accidental needle sticks and other public health concerns by reducing barriers to disposal options. We are asking the Opioid Interim Committee to fund 10 around the state. They cost about $4,000 plus local disposal sources (plus landowner approval) per disposal.

3) **MAT in jails.** I support the MAT in jails that others are probably sending to the committee.

Lisa Raville
Executive Director
Harm Reduction Action Center

Recommendations from Kathryn Wells, Denver Health Clinic at the Family Crisis Center

Thank you for the work you're doing to address substance use in our state. As one of the co-chairs of the Colorado Substance Exposed Newborns (SEN) Steering Committee, I encourage you to take the opportunity to address the intersection of substance use and maternal/child health.

As a physician who provides care for children who have experience child abuse and neglect, I see firsthand the way families in our state are impacted by substance use, and I feel the impact of our growing numbers of women who aren't getting the substance use disorder treatment they need. This includes infants that are born exposed to drugs and alcohol prenatally and their mothers struggling to address their addiction with limited resources while meeting the needs of a new infant. And children left home alone or found wandering in parks while their parent is out drinking or using and selling drugs. Children and youth suffering the effects of exposures to drug and alcohol abuse as well as violence including poor healthcare, inadequate immunizations, dental decay and severe behavioral health issues.

However, through my work as an active member of the American Academy of Pediatrics-Colorado Chapter, the Colorado Substance Exposed Newborns (SEN) Steering Committee, and ECHO Colorado and through my role as a clinical researcher with Kempe Center for the Prevention and Treatment of Child Abuse, I know we have many evidence-informed opportunities to address our state's needs related to perinatal substance use. ***That's why I support the SEN Steering Committee's policy recommendations which were presented at your August 14th meeting:***

1) **Update the Colorado Children's Code to align with federal Child Abuse Prevention & Treatment Act requirements related to Substance Exposed Newborns**

    - Remove focus on drug testing at birth and tie in statute to Criminal Code Definitions of Scheduled Substances

2) **Child Fatality Prevention System Recommendation: Support policies to improve caregiver behavioral health, such as:**

    - Screening and referral during the perinatal period
    - Health insurance coverage
    - Behavioral health integration into primary care

3) **Increase Access to and Support Continuation of MAT in jails, specifically for pregnant or postpartum women**

    - MAT is necessary to prevent acute withdrawal that can be detrimental to maternal-fetal health—particularly for pregnant women who are adhering to a program.
    - Jail and/or incarceration can interrupt a pregnant woman's adherence to a program, putting both her health and her fetus's health at risk.

4) Improve access and utilization of perinatal medical care and substance use disorder treatment

- Pilot co-location of obstetric and MAT/SUD treatment facilities to provide more holistic care to pregnant women with SUDs
- Pilot Expansion of Special Connections Eligibility and Provider Network
- Pilot practice transformation grants for obstetric practices to increase behavioral health integration using the model developed and tested by the State Innovation Model (SIM) Practice Transformation Project

5) Additional Policy Considerations

- **Data:** Improve data collection, interoperability of data collection systems, and data sharing to inform decision making and improve practice related to addressing the impact on children of caregiver substance use—including child fatality data, child welfare data, medical data, public health data.
- **Home Visitation:** Support existing efforts to scale a continuum of home visiting programs across the state.
- **Child Care:** Expand child care options for parents accessing substance use disorder treatment and recovery services.
- **FASD & Juvenile Justice:** Pilot an FASD screening and referral program within juvenile justice to evaluate resource needs and cost savings

These recommendations are the result of professionals from a host of disciplines putting their heads together to address the issue of perinatal substance use, and I hope you'll join us in addressing this issue by creating a maternal/child health bill including a number of these recommendations.

In gratitude for your efforts to support Coloradans,

Sincerely,

Kathryn Wells, MD, FAAP
Medical Director, Denver Health Clinic at the Family Crisis Center
Child Abuse Pediatrician, Denver Health and Children's Hospital Colorado
Associate Professor, University of Colorado School of Medicine
Clinical Researcher, Kempe Center for the Prevention and Treatment of Child Abuse
Community and Partner Liaison, ECHO Colorado

Recommendations from Alyson Williams, Health District of Northern Larimer County

The Health District of Northern Larimer County commends the committee as it continues its work to transform Colorado's approach to all substance use disorders to ensure thorough assessment, appropriate treatment, and access to services. Because substance use disorders have an enormous impact on our community we have studied the issue carefully, and when the call for suggestions came out, we quickly drafted the following recommendations:

1) **Improve comprehensive assessments**

- Implement a standardized substance use disorder (SUD) assessment, using American Society of Addiction Medicine (ASAM) criteria, to assist with proper treatment placement at all levels
- Assure that a person with a SUD has access to psychiatric assessment (by a psychiatrist that has a subspecialty board certification in addiction psychiatry) in order to identify any underlying mental illness

2) **Increase evidence-based withdrawal, treatment, and recovery capacity**

- More beds need to be created and available for medically monitored detox, medically managed detox, inpatient, and residential treatment, as well as long term recovery residences
- All services should follow state-of-the-art standards of care

3) **Increase access to and utilization of medication-assisted treatment (MAT) and treatment**

- Require all SUD services funded by the state to have MAT available, and allow patients to start and stay on MAT at all levels of treatment
- Require detox services funded by the state to offer induction (the moment when an individual "goes off" the drug to prepare for starting MAT) and initiation of MAT
- Prohibit blanket policies against the utilization of MAT in any setting (treatment, correctional, detox, etc.)

4) **Increase access to medication-assisted treatment (MAT) in jails & prisons**

- Allow for the utilization of all MAT options (methadone, buprenorphine, and naltrexone)
- Ensure that individuals can initiate MAT upon entry to all corrections facilities and continue upon their release
- Ensure that individuals who are on MAT upon entry into any corrections facility can continue while in jail/prison

5) **Increase access to naloxone for those within the correctional system**

- Require provision of naloxone to an individual with a diagnosis of opioid use disorder upon release from a correctional facility
- Require that naloxone be available to use within correctional facilities and that staff be trained on its use

6) **Require continuing medical education on substance use disorders for all health professionals to renew their certifications or licensures in the state**

7) **Incentivize psychiatrists to become board certified in addiction psychiatry**

8) **Allow crisis stabilization units to accept individuals who are in a mental health crisis but also have a substance "on-board"**

9) **Consider a more comprehensive federal 1115 waiver with more time for the development of additional facets to address substance use disorders**

Please contact Alyson Williams if you have any questions.

Alyson Williams, MPH
Policy Coordinator
Health District of Northern Larimer County

Recommendation from Lisa Pearson, Nurse Anesthetist

Expansion of the authority to recommend marijuana to Advanced Practice Nurses (APRN) and Physician's Assistants (PA). Our state lists severe pain as an indication and in patients with chronic pain this can be an alternative to opioids. The fact that we can write a prescription for Fentanyl but not recommend marijuana does not make sense to me. There are multiple states that include APRNs and PAs in their medical marijuana statutes:

- Washington DC
- Connecticut
- Hawaii
- Maine
- Maryland
- Massachusetts
- Minnesota
- New York
- New Mexico
- New Hampshire
- Washington State
- Rhode Island
- North Dakota
- Vermont

Recommendations from Dr. Pastora Garcia-Jones, Substance Exposed Newborn Steering Committee

Thank you for the work you are doing to address substance use in our state. As a Neonatologist at Memorial Hospital in Colorado Springs and as Neonatal ICU medical director at Parkview Medical Center in Pueblo, I urge you to consider ways to address the intersection of substance use and maternal/child health.

As a physician who provides care for newborns who are experiencing withdrawal from substances on a daily basis, I see firsthand the way families in our state are impacted by substance use. The increase in opioid use in our Colorado communities has been followed by a sharp increase in babies born with neonatal abstinence syndrome (withdrawal from substances). In one of our southern Colorado Neonatal ICUs, we saw a 20- fold increase in the incidence of neonatal withdrawal from 2010 to 2012, and it remained 10-fold higher than 2010 in 2016. In my work with these at-risk families, I have noticed some strong patterns:

- Mothers without access to health care seldom choose to enter drug treatment before or after delivery. More commonly, their drug use is discovered when their babies undergo withdrawal after they are born, if at all.

- There is a lack of uniformity of drug use screening (verbal) and testing (urine or other toxicology) at Obstetrician's offices and in delivery hospitals. This perinatal period, before the baby is born, and early in pregnancy, is a golden opportunity to screen, support, and hopefully lead mothers to treatment. This opportunity is often being missed due to lack of evidence-based guidelines for drug screening, limited drug treatment capacity and social work support at perinatal clinics.

- When mothers who are in medically-assisted treatment (e.g. methadone clinics) are allowed to actively participate in the care of their withdrawing babies, they are more likely to stay in treatment and seek help as needed. Their babies also finish the withdrawal process sooner and are ready for discharge to home in less time (Grossman et al, 2017). In 2017 over a dozen Colorado hospitals begun to apply a paradigm shift in our approach to the treatment of babies undergoing withdrawal. This effort is the Colorado Hospitals Substance Exposed Newborns (CHoSEN) Collaborative. The shift is away from medical treatment (with morphine or methadone) and towards non-pharmacologic methods (breast feeding on demand, holding, cuddling, pacifier use) as first-line treatment. This paradigm shift was pioneered in 2016 by the state of Massachusetts and already some of the participating Colorado hospitals are seeing remarkable decreases in length of stay which parallel those noted in Massachusetts (where Neonatal ICU length of stay decreased from about 23 days to about 6 days and average cost of stay decrease from $44,824 to $10,289. Grossman et al, 2017). This novel strategy hinges on parents being primary providers of soothing care in the hospital. Their physical presence is essential. As such, family-friendly sized rooms and hospital support are necessary, though not often available in the numbers that are needed. The rewards of this new strategy, both financial (in dramatically decreased length of hospitalization) and in terms of prevention of harm (to babies, by strengthening the mother-baby bond) and decrease in recidivism in mothers who experience parenting success cannot be overstated.

- In order to truly practice prevention in clinics and at delivery hospitals, robust social work support both at both locations is needed. Social work support is sorely lacking in some rural hospitals, and in most clinics. The pattern I have witnessed is that social work is least available in high risk rural communities and small community hospitals. This problem must be addressed if we are to successfully support at-risk families, promote entry into drug treatment, address other factors that lead to drug recidivism such as mental illness, and create much-needed plans of safe care when discharging babies to high-risk environments.

- There appears to be a lack of treatment facilities that can accommodate mothers and their babies (and other children). The inability to have their other children with them during inpatient treatment, or the need to travel long distances to get treatment, has been a strong deterrent to enter treatment for a significant group of mothers whom I have encountered in my practice.

Through my work as an active member of the American Academy of Pediatrics-Colorado Chapter, the Colorado Substance Exposed Newborns (SEN) Steering Committee, and the Colorado Hospital SEN Collaborative, I know we have many evidence-informed opportunities to address our state's needs related to perinatal substance use. That's why I support the SEN Steering Committee's policy recommendations which were presented at your August 14th meeting:

1) **Update the Colorado Children's Code to align with federal Child Abuse Prevention & Treatment Act requirements related to Substance Exposed Newborns**

    - Remove focus on drug testing at birth and tie in statute to Criminal Code Definitions of Scheduled Substances

2) **Child Fatality Prevention System Recommendation: Support policies to improve caregiver behavioral health, such as:**

    - Screening and referral during the perinatal period
    - Health insurance coverage
    - Behavioral health integration into primary care

3) **Increase Access to and Support Continuation of MAT in jails, specifically for pregnant or postpartum women**

    - MAT is necessary to prevent acute withdrawal that can be detrimental to maternal-fetal health—particularly for pregnant women who are adhering to a program.
    - Jail and/or incarceration can interrupt a pregnant woman's adherence to a program, putting both her health and her fetus's health at risk.

4) **Improve access and utilization of perinatal medical care and substance use disorder treatment**

    - Pilot co-location of obstetric and MAT/SUD treatment facilities to provide more holistic care to pregnant women with SUDs
    - Pilot Expansion of Special Connections Eligibility and Provider Network

- Pilot practice transformation grants for obstetric practices to increase behavioral health integration using the model developed and tested by the State Innovation Model (SIM) Practice Transformation Project

5) Additional Policy Considerations

- **Data:** Improve data collection, interoperability of data collection systems, and data sharing to inform decision making and improve practice related to addressing the impact on children of caregiver substance use—including child fatality data, child welfare data, medical data, public health data.
- **Home Visitation:** Support existing efforts to scale a continuum of home visiting programs across the state.
- **Child Care:** Expand child care options for parents accessing substance use disorder treatment and recovery services.
- **FASD & Juvenile Justice:** Pilot an FASD screening and referral program within juvenile justice to evaluate resource needs and cost savings

These recommendations are the result of professionals from a host of disciplines putting their heads together to address the issue of perinatal substance use, and I hope you'll join us in addressing this issue by creating a maternal/child health bill including a number of these recommendations.

In gratitude for your efforts to support Coloradans,

Pastora Garcia-Jones, MD

Staff Neonatologist at Children's Hospital Colorado at Memorial Hospital in Colorado Springs; Staff Neonatalogist and Medical Director of NICU Parkview Medical Center, Pueblo;
SEN Steering Committee member; CHoSEN Collaborative Hospital Learning Group Co-Chair.

Recommendations from Ellen Stern, Children's Hospital Colorado

I testified briefly to the opioid interim committee last week and I wanted to follow-up to submit written comments as requested by Rep. Pettersen. Again, thank you all for taking the time to examine the important maternal and child health connections with substance use disorders, and we hope this is an issue that you decide to highlight in future legislative proposals.

As shared during committee, in Colorado approximately 2.9/1,000 births involved a substance exposed newborn in 2013, compared to 2003 when 0.6/1,000 births involved substance exposed newborns. According to the Centers for Medicare & Medicaid Services, nationally, 80% of babies born with neonatal abstinence syndrome are enrolled in Medicaid.

Despite the growing knowledge and understanding of the science of addiction as a chronic relapsing medical condition, individuals with substance use disorders continue to experience stigmatization. Pregnant women who use substances bear additional stigmas because of the potential of prenatal substance use to cause fetal harm. They may feel dissuaded from seeking prenatal care as a result.

Due to these barriers, we believe more can be done to ensure women with substance use disorders are appropriately accessing prenatal care for their babies as this is a critical time for baby's development and growth; early interventions and supports can potentially contribute to long-term cost savings. The committee should consider piloting behavioral health integration in obstetric practices as well as facilitating access to prenatal care in MAT clinics. These policies could help ensure that children who are exposed prenatally to substances may still have the opportunity for a healthy and strong start in life. The goal of a maternal-child health policy would be to ensure greater access to prenatal, postpartum, and substance use disorder treatment concurrently.

We have been working with a small stakeholder group comprised of Children's Hospital Colorado, Illuminate Colorado, Mental Health Colorado, and the Children's Campaign to discuss policy options that we believe the committee should consider. We have also been in communication with the Colorado Chapter of the American College of Obstetricians and Gynecologists as well as our state agency partners.

Additional articles that may help to frame this issue include:

- http://www.pewtrusts.org/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest
- https://www.rand.org/pubs/external_publications/EP67309.html

Please let me know if you have any questions or if you would like to discuss in more detail before the next committee meeting. Thank you for your consideration of this important issue for mothers and their babies.

Sincerely,
Ellen Stern, Senior Policy Coordinator, Government Affairs. Child Health Advocacy Institute

Recommendations from Jillian Adams, Illuminate Colorado

Thank you again for the opportunity to present to the committee this week. We wanted to share our policy recommendations via email as well. We would be happy to continue the conversation around any of these recommendations.

Best,
Jillian

SEN Steering Committee Policy Recommendations:

1) **Update the Colorado Children's Code to align with federal Child Abuse Prevention & Treatment Act requirements related to Substance Exposed Newborns**

    - Remove focus on drug testing at birth and tie in statute to Criminal Code Definitions of Scheduled Substances

2) **Child Fatality Prevention System Recommendation: Support policies to improve caregiver behavioral health, such as:**

    - Screening and referral during the perinatal period
    - Health insurance coverage
    - Behavioral health integration into primary care

3) **Increase Access to and Support Continuation of MAT in jails, specifically for pregnant or postpartum women**

    - MAT is necessary to prevent acute withdrawal that can be detrimental to maternal-fetal health—particularly for pregnant women who are adhering to a program.
    - Jail and/or incarceration can interrupt a pregnant woman's adherence to a program, putting both her health and her fetus's health at risk.

4) **Improve access and utilization of perinatal medical care and substance use disorder treatment**

    - Pilot co-location of obstetric and MAT/SUD treatment facilities to provide more holistic care to pregnant women with SUDs
    - Pilot Expansion of Special Connections Eligibility and Provider Network
    - Pilot practice transformation grants for obstetric practices to increase behavioral health integration using the model developed and tested by the State Innovation Model (SIM) Practice Transformation Project

5) **Additional Policy Considerations**

    - **Data:** Improve data collection, interoperability of data collection systems, and data sharing to inform decision making and improve practice related to addressing the impact on children of caregiver substance use—including child fatality data, child welfare data, medical data, public health data.

- **Home Visitation:** Support existing efforts to scale a continuum of home visiting programs across the state.
- **Child Care:** Expand child care options for parents accessing substance use disorder treatment and recovery services. Illuminate Colorado is working with CDHS to explore models for rural and urban pilots.
- **FASD & Juvenile Justice:** Pilot an FASD screening and referral program within juvenile justice to evaluate resource needs and cost savings

Jillian Adams, MSW
Substance Exposed Newborns Program Manager
Illuminate Colorado

Recommendations from Lauren Snyder, Mental Health Colorado

Mental Health Colorado would like the Opioid Interim Committee to sponsor legislation that includes the following policy recommendations:

1) **Creation of a care coordination entity or system that would determine the level of care *independent* of any particular provider**

    - One number to call
    - Entity or system serves people regardless of who is paying for treatment
    - Entity or system coordinates care for people as they are released from jail
    - Entity or system will screen individual for level of care they need and coordinates care

2) **Require all SUD providers and care coordination entity to use a standardized level of care criteria (for example, ASAM criteria) when determining level of care**

3) **Create a comprehensive capacity tracking system**

    - System must be mandatory for all providers and be updated *at least* once per day, preferably upon admission
    - System will track inpatient and residential psychiatric and substance use beds
    - System will track MAT providers

4) **Expanded investment in outpatient services, with particular attention towards intensive outpatient services. Possible options include:**

    - Support local communities to create capacity in underserved counties and/or counties that do not have any services.

        a) Direct seed money to local communities for 3-5 years to help them create solutions that work for their community (MAT, integrated physical health clinics to reduce stigma and barriers to care)
        b) This would allow communities to run or contract with provider of their choice
        c) Providers would then bill Medicaid, private insurance, and OBH to cover operational costs after seed money ends

    - Additional money through existing MSO structure

        a) Money would need to be specifically slated for the creation of *new* providers in counties that currently do not have any services and require the creation of outpatient services (MAT, OTPs, Intensive outpatient)

5) **Support pilots around maternal health (Also supported by Illuminate Colorado, Children's Campaign, and Children's Hospital)**

- (Top Priority for us) Pilot practice transformation grants for obstetric practices to increase behavioral health integration using the model developed and tested by the State Innovation Model (SIM) Practice Transformation Project
- Pilot co-location of obstetric and MAT/SUD treatment facilities to provide more holistic care to pregnant women with SUDs
- Pilot Expansion of Special Connections Eligibility and Provider Network

LAUREN SNYDER
State Policy Director
Mental Health Colorado

Recommendations from Pauline Whelan, Orexo

1) **Eliminate Barriers to Treatment such as Prior Authorizations for Opioid Used Disorder (OUD) Medications:**

   OUD patients not instantly engaged in treatment are highly susceptible to relapse. There should be no initial barriers to admitting patients to treatment and every FDA approved medication used in treating OUD should be made available without a prior authorization, step therapy, time limits or any other utilization management.

2) **Establish Credible Patient/Provider Linkages With a Dedicated List of Credentialed Opioid Used Disorder (OUD) Providers; Ensure Network Capacity is Sufficient to Meet the Treatment Gap:**

   Patients compromised by addiction need easy and immediate access to care. Requiring plans to provide a dedicated list of plan credentialed providers and their services to patients will significantly improve patient navigation of this system. Greater oversight of plan network capacity to ensure the treatment gap is met is not only essential to treating patients it also reduces fraud and abuse that patients encounter outside their insurance product. Payers must encourage the treatment of this disease within an insured market by building comprehensive networks through appropriate provider incentives.

3) **Criminal Justice Increase Access to MAT behind the walls**

   Standardize treatment options for MAT across all jails in state – ensure that all individuals who are on MAT can continue on that particular medication and those who are not on MAT can be detoxed and initiated on an MAT upon entry and continue it upon release.

   Initiate a pilot program for MAT in the Prison re-entry population, and continue it upon release, by referring individuals to MAT treatment options in the community.

4) **Expand and Appropriately Reimburse Services in Opiate Treatment Programs ("OTP" - Methadone Clinics) to Include All Forms of Medication Assisted Treatment**

   Methadone clinics have significant experience in treating OUD. These facilities need to be appropriately reimbursed and incentivized to expand their services to treating patients with all forms of medication assisted therapies. The medication or treatment that is best for one patient may not be the best treatment for the next patient. Choices of proven treatments is a vital weapon in the war on opioid addiction. This will significantly increase treatment capacity to meet the demand brought by this epidemic.

Recommendations from Kenneth Finn, MD

I received a request from Dr. Jon Clapp and Colorado Pain Society to reach out to you regarding my input regarding Colorado's opioid epidemic.

I understand there may be a meeting next week where I was asked to provide some input to the committee. My particular position would be that the American Board of Pain Medicine be recognized by the State of Colorado, just like several other states and organizations have already done (see attached).

In this day and age of opioids, it is critical that physicians who are to manage pain, particularly chronically, have more than basic training in Pain Medicine. Most physicians who are licensed and have a DEA typically have no significant Pain Medicine training. The slippery slope of opioid prescribing can easily get out of hand and soon there's a patient on high dose opioids who may be at risk for overdose. Some of these patients can become challenging, particularly with multiple medical co-morbidities, complicated medication regimens with several potential drug interactions, and in the elderly.

It would be important that these patients are managed by physicians well trained in Pain Medicine and have experience managing such patients. This will be only one aspect of pushing back on the opioid epidemic and some of my colleagues are helping you on other issues, along with Colorado Medical Society and Colorado Pain Society.

Please find my CV attached and let me know if there is opportunity to assist with this complicated issue.

Regards,

Kenneth Finn, MD

Recommendations from NORML (submitted by multiple individuals)

As a Colorado resident I urge the committee to review the abundance of data demonstrating access to marijuana reduces the number of opioid-related deaths, hospitalizations, and total number of opioids prescribed.

Opioid-involved overdose deaths have increased five-fold since 1999 and were involved in over 40,000 deaths in 2016. Deaths involving benzodiazepines, a family of anti-anxiety drugs, have increased eight-fold during this same time.

Best evidence informs us that access to medical marijuana is associated with reduced levels of opioid-related abuse, hospitalization and mortality.

In April of this year, the esteemed Journal of the American Medical Association, Internal Medicine published a pair of persuasive new studies reinforcing this opinion.

In the first study, investigators from the University of Kentucky and Emory University assessed the relationship between medical and adult-use marijuana laws and opioid prescribing patterns among Medicaid enrollees nationwide. Researchers reported that the enactment of both medicalization and adult-use laws were both associated with reductions in opioid prescribing rates, with broader legalization policies associated with the greatest rates of decline.

In the second study, University of Georgia researchers evaluated the association between the enactment of medical cannabis access laws and opioid prescribing trends among those eligible for Medicare Part D prescription drug coverage. Researchers reported that medicalization, and specifically the establishment of brick-and-mortar cannabis dispensing facilities, correlated with significantly reduced opioid prescription drug use.

A prior study reported in the same journal in 2014 determined, "States with medical cannabis laws had a 24.8 percent lower mean annual opioid overdose mortality rate compared with states without medical cannabis laws."

The available data is consistent and clear. For many patients, cannabis offers a viable alternative to opioids. It is time for lawmakers to stop placing political ideology above the health and safety of the American public, and to acknowledge the safety and efficacy of marijuana as an alternative medical treatment.

You can see many more published studies on the NORML factsheet Relationship Between Marijuana and Opioids here: http://norml.org/marijuana/fact-sheets/item/relationship-between-marijuana-and-opioids

Recommendations from Qing Li, MD, DrPH, Epidemiologist

Monitor patient data and behavioral nudges to improve adherence to Prenatal Screening, Brief Intervention, & Referral to Treatment (SBIRT) for prompt Medication-Assisted Treatment (MAT)

Short title: Prenatal SBIRT pilot for prompt MAT

Qing Li, MD, DrPH, representing herself, an epidemiologist from University of Colorado Denver, Department of Pediatrics, Colorado Consortium Work Groups (Data and Research, Heroin Response, Provider Education, and Treatment), State Epidemiology Outcomes Workgroup (SEOW), Graduate School of Public Health, SDSU

A Policy Idea, which received written comments from 22 stakeholders in the past one year

Inspired by SB 17-074 MAT pilot (PI Mary Weber) and statutes in Kentucky 2005 & Minnesota 2010, this 2-year pilot idea *Monitor patient data and behavioral nudges to improve adherence to Prenatal Screening, Brief Intervention, & Referral to Treatment (SBIRT) for prompt Medication-Assisted Treatment (MAT)* seeks marijuana tax revenues ($350K/y, 2 years, 1.7 FTE) to investigate data, barriers & facilitators. A successful public health approach requires data driven and integrated systems (e.g., medicine, public health, social welfare, law enforcement, families, NGO, et al) of response. On 10/23/17, I testified this stakeholder proposal to amend Prevention Bill 18-0255 in the opioid Interim Study Committee. I hope this Committee can champion this prevention effort in system changes and consider it in the new cycle in 2018.

Gaps in Colorado (CO)

1) Lack of legislative champion to protect pregnant women, the sentinel & priority population in the opioid epidemic and who often deny or underreport substance use (e.g., a concern of loss of child custody)
2) Incomplete & delayed data on opioid exposed maternal death & neonatal abstinence syndrome in CO
3) Under-reported and under-utilized SBIRT procedural codes in Claims data & Electronic Health Records
4) Lack of facility and county-level monitoring of prenatal SBIRT measures
5) Delayed or missed access to medication-assisted treatment (MAT) or the Special Connection Program

Long-Term Goals

Institutionalize universal & prompt prenatal SBIRT, reduce stigma, increase MAT access, eliminate cost, prevent prenatal substance use, and manage substance exposed moms & newborns in CO.

Baby Milestones and Short-Term Goals

1) Leverage federal funding, revise the unfunded proposal on prenatal SBIRT documented in All Payer Claims Data and Electronic Health Records HRSA-19 R40 Maternal and Child Health Bureau Secondary Data Analysis from SDSU, subcontract UC Denver, $100K, due X/2019, start 7/1/2019)
2) Form an advisory board, collect comments, share concepts, and engage stakeholders and agencies
3) Increase facility capacity in monitoring prenatal SBIRT in selected counties and facilities including jails
4) Promptly identify substance exposed pregnancy and newborns for prompt service
5) Increase MAT access among pregnant women and decrease impacts of substance on two generations
6) Provide sufficient data for continued statewide programs and policy initiatives

Steps at Health Facilities and Advisory Board

1) Identify counties with diverse health facilities and the potentials for successful implementation
2) Compile existing SBIRT data, explore new data sources (e.g., Electronic Health Records, All Payer Claims Data) and monitor facilities including jail or prison in selected counties to determine the rates and timing of SBIRT, the prevalence of substance exposed pregnancy and newborns;
3) Evaluate the quality of SBIRT (e.g., frequency, timing), treatment, & outcomes (e.g., symptoms, length of stay, morphine use, transfers, developmental outcomes, miscarriage, stillbirth, and costs) in facilities;
4) Work with each facility including jail or prison to establish a process to standardize the reporting, gather, and analyze data within protocols that protect the confidentiality of patient identification;
5) Engage patient, provider and health systems stakeholders in designing, refining, and implementing
6) Report the evaluation annually and provide assistance and incentives to improve performance.

Recommendation from Chris Coddington

Sober Living Home Licensure and Regulation

A bill regulating sober living homes in the State of Colorado must begin by defining the industry. The National Council for Behavioral Health and the National Association of Recovery Residences (NARR) have detailed sample legislative language on page 17 of their "State Policy Guide for Supporting Recovery Housing"[1]. A bill regulating the sober living home business must also establish a compulsory licensing program or scheme, whereby the operator is required to provide minimal pertinent information (e.g. where the houses are, how many residents are in the home, lease agreement with owner, qualifications of "house manager" if there is one etc.), to the state Office of Behavioral Health (OBH) within CDHS, and whereby the license may be revoked for serious violations of sober home resident rights, neighboring residents rights, financial improprieties against residents, or other predatory behavior. The bill shall require sober living homes to notify local governments of their presence, and should make it clear that neither the city nor state will make decisions (and will not respond to such complaints or inquiries) based on fear, prejudice or speculation. Fines should be levied against operators for not getting a license with the OBH, and such fines should be substantial, at least $1,000 per home, so it is taken seriously. The operators should be required to post their license in a visible location at the home and to post a "patient rights" poster that provides the number for OBH to report violations. NARR, or their Colorado affiliate CARR, is best suited to draft the patient rights language.

A comprehensive bill regulating the sober home industry must reinforce and clarify the ability of local governments to zone these businesses. Sober homes are located in residential neighborhoods and protected by the Federal Fair Housing and Disability Law, but local governments remain unclear on what they can and can't do under the 2016 Dept. of Justice, FHA guidance[2]. Current state law C.R.S. 31-23-303(2)(b.5)[3] and C.R.S. 30-28-115(2)(b.5)[4] states that, "A state-licensed group home for eight persons with behavioral or mental health disorders is a residential use of property for zoning purposes, . .." This law makes it seem that if the number of residents in a group home is 8 or under it is "use by right". This does not do justice to the fact that small group homes can also be unsafe and remain unregulated. Existing legislation dictates a 750ft spacing requirement between small group homes of up to 8 persons. New legislation should remove the spacing language and add a statement providing authority to local governments to enact spacing and capacity requirements based on building or fire/building code and to address concerns about concentration of services.

---

[1]Criss et al. Building Recovery: State Policy Guide for Supporting Recovery Housing https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolkit_5.3.2018.pdf

[2]STATE AND LOCAL LAND USE LAWS AND PRACTICES AND THE APPLICATION OF THE FAIR HOUSING ACT, November 10, 2016, https://www.justice.gov/crt/page/file/909956/download

[3]C.R.S. 31-23-303(2)(b.5), https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=d93748ad-0b0f-411e-8dc6-e2e846009b26&nodeid=ABGAAEAAFAADAAD&nodepath=%2FROOT%2FABG%2FABGAAE%2FABGAAEAAF%2FABGAAEAAFAAD%2FABGAAEAAFAADAAD&level=5&haschildren=&populated=false&title=31-23-303.+Legislative+declaration&config=014FJAAyNGJkY2Y4Zi1mNjgyLTRkN2YtYmE4OS03NTYzNzYzOTg0OGEKAFBvZENhdGFsb2d592qv2Kywlf8caKqYROP5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A5STP-1GD0-004D-12DT-00008-00&ecomp=-Jxv9kk&prid=3e717bd9-4377-41bc-ab41-fc657256ada9

[4]https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=d93748ad-0b0f-411e-8dc6-e2e846009b26&nodeid=ABGAAEAAFAADAAD&nodepath=%2FROOT%2FABG%2FABGAAE%2FABGAAEAAF%2FABGAAEAAFAAD%2FABGAAEAAFAADAAD&level=5&haschildren=&populated=false&title=31-23-303.+Legislative+declaration&config=014FJAAyNGJkY2Y4Zi1mNjgyLTRkN2YtYmE4OS03NTYzNzYzOTg0OGEKAFBvZENhdGFsb2d592qv2Kywlf8caKqYROP5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A5STP-1GD0-004D-12DT-00008-00&ecomp=-Jxv9kk&prid=3e717bd9-4377-41bc-ab41-fc657256ada9

Two Arizona bills[5] address the health and safety requirements by *requiring* that local governments address fire safety requirements and "square footage and location requirements of the residents' bedrooms."[6] I endorse Arizona's legislative approach and urge its enactment in Colorado. Per the HUD/FHA guidance state and local governments may impose spacing requirements so long as the requirement is applied neutrally to those without a disability as well as those that are in a protected class.[7]

Local governments are better able to assess the needs of their community based on spacing and capacity requirements. In fact, this is traditionally in their bailiwick. The language allowing local govts. to space group homes in a neutral non-disparate way could be lifted directly from the joint guidance because the guidance refers to a "fundamental alteration of the local govts. zoning scheme" in several places in the document.[8] My recommendation is that the proposed legislation state that "Local govts. may enact spacing and capacity requirements for group homes if the application of the requirements does not result in a "disparate impact" for protected residents and if the requirements are a fundamental component of the local govts. zoning scheme".

[5]AZ HB 2107, https://www.azleg.gov/legtext/52leg/2r/bills/hb2107p.pdf and AZ SB 1465, https://www.azleg.gov/legtext/53leg/2R/bills/sb1465p.pdf

[6]AZ HB 2107, https://www.azleg.gov/legtext/52leg/2r/bills/hb2107p.pdf Line 41-42

[7]STATE AND LOCAL LAND USE LAWS AND PRACTICES AND THE APPLICATION OD THE FAIR HOUSING ACT, November 10, 2016, https://www.justice.gov/crt/page/file/909956/download pg 12

[8]STATE AND LOCAL LAND USE LAWS AND PRACTICES AND THE APPLICATION OD THE FAIR HOUSING ACT, November 10, 2016, https://www.justice.gov/crt/page/file/909956/download pg 8, 15, 16, 18

Recommendations from Kristen Dixion, Addiction Research and Treatment Services

Per request for legislative/policy areas of focus, please see below.

The cost of substance use disorder treatment and service delivery has increased overtime; however, the rates (i.e., State and local government systems rates - Medicaid, county DHS, Probation, OBH/MSO, DCJ/DOC, etc.) for service delivery have not increased at the same pace. Personnel costs, benefits costs, operating expenses and inflation adjustment need to be considered. It is a challenge to hire and retain qualified staff with the current rates, especially competing with State entities. It is imperative adjusted rate increases need to be identified and supported across the continuum. The behavioral health system is not keeping up with the changing landscape and increasing costs.

Another area of concern is parity for SUD and MH services.

Sincerely,

Kristen

Kristen Dixion, MA, LPC | Executive Director
Addiction Research and Treatment Services | Department of Psychiatry
University of Colorado Anschutz Medical Campus

Recommendations from Angela Bonaguidi, Colorado Organization for the Treatment of Opioid Dependence (COTOD)

Dear Members of the Committee:

On behalf of the Colorado Organization for the Treatment of Opioid Dependence (COTOD) which represents all NTPs (Narcotic Treatment Programs) in the State of Colorado, thank you for the opportunity to submit bill or policy suggestions.

Suggestion #1:

We strongly advocate that the Colorado Legislature needs to consider parity between healthcare reimbursements, especially for Medicaid as it pertains to medical, mental health, and SUD/MAT. Our unit cost analyses indicate that current Medicaid SUD/MAT reimbursements are insufficient to create or sustain, a collaborative and integrated system of patient care. Furthermore, many private insurance providers do not recognize methadone as a covered intervention when provided by Narcotic Treatment Programs (NTP) and Medicare does not provide an NTP benefit.

Suggestion #2:

Per Office of Behavioral Health Rule 21.210.1.B., SUD providers must employ 50% or more of its staff clinicians who are certified as a Certified Addiction Counselor II or III, or as a Licensed Addiction Counselor. COTOD respectfully suggests that the rule is changed to read, "At least fifty percent (50%) of all treatment staff in substance use disorder programs within each licensed site, excluding non-hospital residential detoxification, shall be certified, or actively working toward, a Certified Addiction Counselor II (CAC II), Certified Addiction Counselor III (CAC III) or Licensed Addiction Counselor (LAC)."

Colorado should be first in our nation to review parity laws that have existed for the past decade, and take on the challenge to enact or changes laws to positively affect our residents' health outcomes.

Thank you for your consideration.

Sincerely,

Angela Bonaguidi, LCSW, LAC, MAC, MSW
President
Colorado Organization for the Treatment of Opioid Dependence (COTOD)

Recommendations from Daniel Caplin, Colorado Addiction Treatment Services, Inc.

My name is Daniel Caplin, I run the opioid treatment program and addiction medicine Center in Durango Colorado, currently covering patient's from the surrounding 6 counties. I am Board certified by the American Board of Addiction Medicine. Our treatment center has been open for 3 years and currently have approximately 170 patient's. We are providing medication assisted treatment including methadone, buprenorphine products as well as outpatient alcohol detox and addiction treatment. We are CARF Accredited, and have licenses from the DEA and OBH. Approximately 95% of our clients are on Colorado Medicaid. This state of addiction treatment in rural Colorado is in shambles. Treatment providers that accept Medicaid are few and far between. There are very few centers that provide methadone which in many cases of more severe opioid addiction is truly the best medication. Methadone administration is extremely regulated as are the clinics that provide the treatment.

I found out today, August 21 at 3:30 at the legislative community was meeting on August 22 and my input would be of value. I have been in the trenches of the opioid addiction crisis for years. I previously worked in emergency medicine for 26 years and have truly been on the front lines of addiction. I was requested to give my input. I am shocked that nobody has reached out to me or my staff regarding the delivery of services in rural Colorado. The only other clinic on the Western slope is in Grand Junction, the clinic in Montrose, closed about 2 months ago.

While I commend people for creating novel ideas for the delivery of services and addiction treatment, the existing infrastructure has been completely neglected. Colorado has received almost $16 million for opioid treatment, this money was distributed in April 2017 and 2018. As the only regional rural opioid treatment center, I find it curious that none of this public grant money has "trickled down "to actually help provide rural addiction treatment. I also am aware that Colorado will be receiving approximately $50 million of grant money for the opioid crisis. Again, I am sadly confident that none of this money will trickle down to assist providing the desperately needed services in this region. I was recently informed that the state of Colorado has authorized this spending of $2 million for rural addiction van's. I was requested to be a "hub" for this region. Is this a good use of funds, when the rural “hubs” are closing?

Currently, I am seriously contemplating closing the OTP due to the lack of adequate reimbursement and 0 public funding. I essentially run a public health clinic without public support. I have not been reimbursed any salary in 6 months and will be making the decision in the next 2 weeks whether or not to close the clinic. In the meantime I am recertifying my emergency medicine boards and am planning on returning to emergency medicine. If we close, and I am about 90% sure we are at this point, the entire region will be desperately devoid of addiction services. There will be an increase in hospitalizations, incarcerations and overdoses. Many studies including the world health organization study on addiction treatment reveal a 12:1 ratio of dollars that the local community saves directly from reduced incarcerations and hospitalizations. For every million dollar spent on addiction treatment, $12 million are saved, not to mention the lives.

Issues of Concern:

The grant system is extremely broken. The grant money distribution is limited to organizations that can employee "grant writers ". This typically is large organizations, and small organizations do not have access to these funds.

Treatment versus incarceration-way too much focus is placed on incarceration rather than getting people adequate treatment. The local jail does not regularly participate in allowing established patient is to continue receiving medication assisted treatment or doesn't encourage current inmates to receive treatment while incarcerated or on upon release.

Social detox centers-these dysfunctional centers should be forced to provide Axis II treatment for the people that are sent there. As an emergency medicine physician I have sent thousands of patient's to social detox only to have them released right back to the streets. These should be getting released to treatment and if not they should be shut down.

Behavioral health needs to be reimbursed commensurate to medical care. Highly trained counselors are currently reimbursed poorly by Medicare and Medicaid.

Addiction treatment needs to be covered by Medicare!

Mental health parity act needs to be enforced and fines need to be instituted upon the insurance companies in violation.

Certain insurance carriers, particularly Anthem, has provided the most unbelievable obstacles for patient's and continue to refuse credentialing of our clinic even after 3 years.

Medicaid for all people with addiction. Insurance companies are creating obstacles and barriers to treatment access. They falsely informed their patients that they have to pay their deductible prior to any insurance kicking in for addiction treatment. When patients seek treatment they should immediately be granted Medicaid even if they have private insurance and have this state recoup the money from the insurance company as the patients themselves have found this impossible.

There needs to be a system to penalize patient's that have Medicaid, from "no showing "to their appointments. Currently our patients show up less than 30% of the time for their counseling sessions. This is standard in the industry from what I am told. The state of Colorado has a ratio of 50 patient's to every counselor if you are providing addiction treatment under an OBH license. This forces us to employ a large number of counselors that are highly inefficient and causes financial harm to the clinics. Private practices charge no-show fees. Currently, we are forbidden from collecting any missed appointment fees from Medicaid and we are unable to bill Medicaid for missed appointments. A $20 no-show fee with likely be adequate.

Improvement in access to residential treatment, currently Medicaid does not cover residential treatment.

System of statewide “medical detox centers” with case management and placement, rather than social detox, which does not work at all

I hope the committee finds my suggestions of use. I did not have much time to gather my thoughts or get them in an email. I will be happy to speak to any of the committee members or welcome a visit to Durango.

Daniel Caplin, DO
Colorado Addiction Treatment Services, Inc.
Durango, CO

Recommendations from Frank Cornelia, Colorado Behavioral Healthcare Council

I know you've all been deluged by policy recommendations again this year. CBHC is supportive of several that you have probably seen more than once by various stakeholders, including boosting early prevention (and doing a better job of coordinating existing funding for prevention at the OBH level). We also support increased funding for treatment services across the continuum and think SB202 funding has gone a long way to making capacity expansion a reality. We are supportive of standards for sober living homes and more resources and coordination for recovery services.

A few recommendations that I think may be more nuanced:

PROBLEM OR ISSUE: Community reliance on jail solution for substance use disorder

Some communities report they are using the EC process outlined in statute (27-81-111 & 27-82-107) to bring individuals whose behaviors are hard to manage into a jail settle regardless if they have substances on board. Colorado moved away from this practice on the mental health side with SB17-207. As a state, we should be seeking treatment options for individuals experiencing SUDs. As we seek a waiver to add inpatient and residential benefit to Medicaid and expand capacity in general, we should look at phasing out the ability to house intoxicated individuals without charges in jail settings.

PROBLEM OR ISSUE: Conflicting or confusing statutory language

Align statute to combine the alcohol (27-81) and drug (27-82) sections to eliminate confusion/misalignment. (this recommendation was supported by the Civil Commitment Task Force in 2013. http://www.oralhealthcolorado.org/wp-content/uploads/2013/11/Civil-Commitment-Task-Force-Report.pdf)

PROBLEM OR ISSUE: More diversion efforts needed

Colorado funded 4 pilots for LEAD in 2017. In order to rely less on the criminal justice system we should codify LEAD and scale up the program statewide. Although I'm aware that CCJJ has sentencing under their purview, we should look at charging and sentencing issues for SUD as a state.

PROBLEM OR ISSUE: Workforce

Continue to expand on loan repayment and scholarship opportunities for SUD professionals. Explore other alternatives to support workforce, including housing support and other supervision/consulting/networking support.

We also heard Rep Singer's question about the MSOs and SB202 at the end of the meeting last week. If needed I am happy to get an MSO perspective presented to the committee on 202 and the critical expansions of services that have occurred under that funding. As a reminder, here is the report the MSO put together last year: https://www.cbhc.org/wp-content/uploads/2018/03/SB202-Report.pdf (and attached)

Please let me know if that is of interest committee members and if I can help in any way.

Thanks!

Frank

Frank Cornelia, MS, LPC
Director of Government & Community Relations
Colorado Behavioral Healthcare Council | CBHC

Recommendations from Louise Silvern, Ph.D, Pain Education Project

Dear Opioid Committee Staff Members:

Please accept the document "Proposed Opioid Legislation," (attached below) as a suggested policy statement concerning opioids and their impact on overdoses and on pain patients. In addition, two further documents are intended to illustrate evidence that supports that suggested policy. Please inform me if you have questions (720-480-6453).

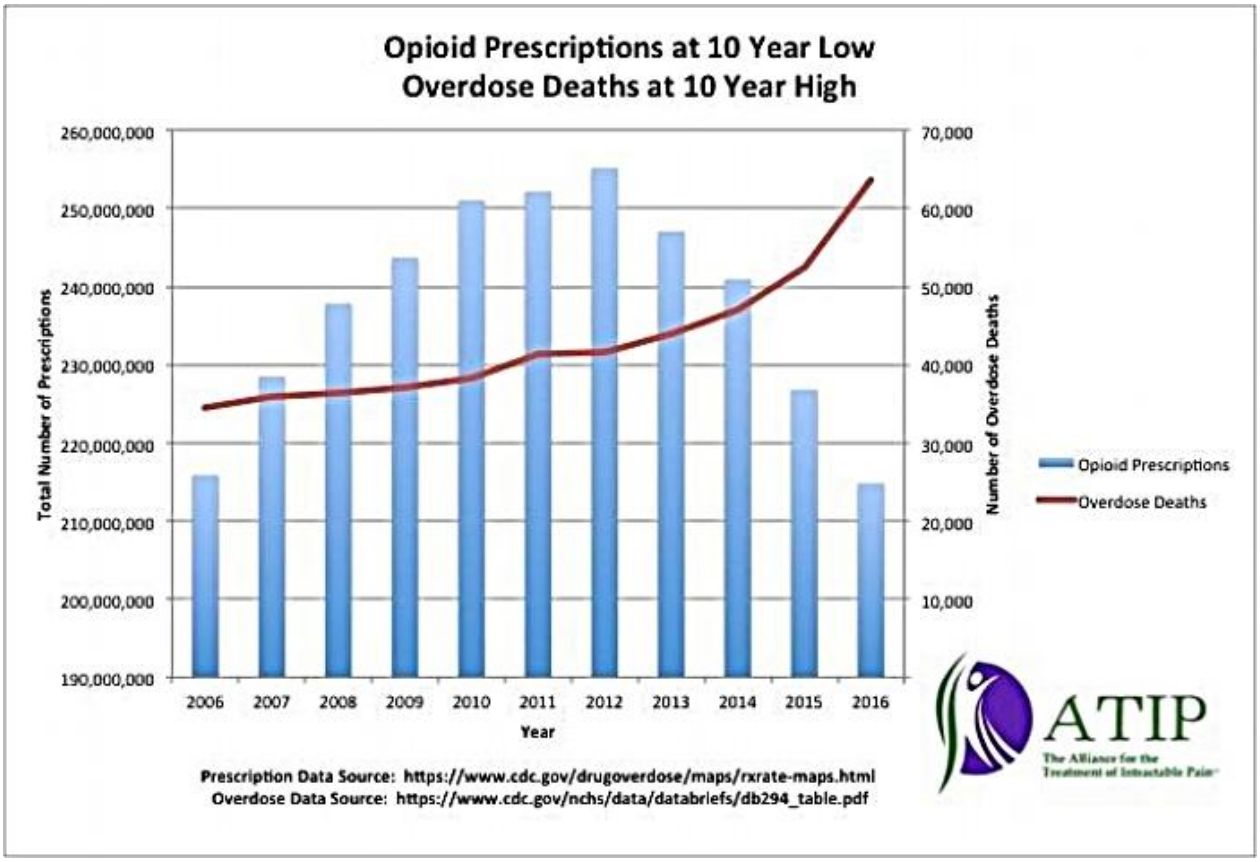
Thank you for your consideration.

Louise Silvern, Ph.D
President, Pain Education Project

PROPOSAL RE: OPIOID POLICY

Evidence demonstrates that attempts to restrict prescriptions of opioid-based medications have not and will not reduce escalating rates of fatal overdoses. Data compiled by the CDC and others demonstrate that the government's efforts to discourage doctors from prescribing opioids and titrate patients regardless of their pain severity or sources have been unsuccessful. The number of prescriptions has declined more than 20% since the Obama Administration and state governments initiated these efforts. However, the number of deaths by overdose has consistently increased. Indeed, opioid-related fatalities have an inverse relationship to the number of legal prescriptions. Moreover, peer-reviewed research indicates that the addicted population is almost completely non-overlapping with that of chronic pain patients and that such patients have miniscule addiction rates, with the exception of those who had prior substance abuse problems. Millions of pain patients had functioned successfully only with the help of opioid medication, until the current ineffective approach to overdoses forced them to endure severe, untreatable medical conditions without that help. Now increasing numbers have become disabled – unable to be employed, due to limited mobility and agonizing pain, and their physicians report that many are finding no alternatives to either (1) intentionally ending their lives or (2) seeking very dangerous, illicit opioids on the streets to ease their pain, thus increasing accidental overdose deaths. Therefore, the approach of titrating patients and intimidating doctors should be abandoned in favor of providing medication-assisted treatment for addiction. Evidence indicates that such treatment is effective in ameliorating the problem of opioid addiction. Trauma-based treatment is also helpful for many who are at risk of overdosing. The underlying causes of addiction are multifaceted and frequently include trauma and economic or social dislocation; placing the blame on doctors or their patients harms both and leaves those who are struggling with addiction without effective treatment. Government policy should reflect these well-established facts. Fortunately, the facts do not suggest that the needs of pain patients and those at risk of overdosing are in conflict with one another, as in the case under the current, mistaken strategy.
A great deal of evidence supports the statement above. Examples are attached below.

Respectfully submitted by Steven Silvern, Attorney at Law, a volunteer with the Pain Education Project, a Colorado non-profit corporation.



VERT RIGHT SIDE = # OD DEATHS (10K – 70K).
VERT LEFT SIDE = number of prescriptions for opioid medications in U.S. (190 -260 million).
RED TREND LINE: Represents number of Overdose deaths.

Data are drawn from CDC.

CONCLUSION: Although the numbers of prescriptions for pain medications have dropped. The numbers of fatal overdoses involving opioid substances have increased over the same period. Obviously restricting prescriptions is not preventing overdoses. *From : Tell Medicare to Stop*

LCS Staff Comment: An additional white paper, "Prescription Opioids and Chronic Pain" by Richard A. Lawhern, Ph.D., The Alliance for the Treatment of Intractable Pain was submitted by Mr. Silvern and is available upon request.

Recommendations from Jamie Feld, Boulder County Public Health

Local Support: Funding for coordination and capacity at the local level

According to findings from the Colorado Association for Local Public Health Organizations (CALPHO) and the Colorado Consortium for Prescription Drug Abuse gathered from representatives from 26 Colorado counties, funding needs exist for coordination of community-based opioid response efforts statewide. We recommend funding for local capacity in coordination along the continuum of care for opioid prevention, harm reduction and recovery services. This local funding could assist both with personnel capacity as well as operating expenses to implement evidence-based strategies tailored to the readiness and feasibility of the local jurisdiction. Communities that have had this type of investment have seen gains. This investment would allow local communities to prepare for application for federal sustainable funding opportunities.

Recovery: Subsidies for training and retention of peer recovery coaches

Peer recovery coaching is a form of strengths-based support for people with substance use disorder. Recovery coaching uses a partnership model wherein the client is considered to be the expert on his or her life, the one who decides what is worth doing, and the coach provides expertise in supporting successful change. Peer recovery coaches may be on-call and often travel to the site where a person is experience the crisis and is in need of support; they may assist in walking a person through the steps to get linked to treatment. Recovery coaching is an evidence-based strategy supported by Substance Abuse and Mental Health Services Administration (SAMHSA). It is currently a billable expense to Colorado Department of Health Care Policy and Financing (HCPF). Incentives to encourage an increase the number of peer recovery coaches would be a cost-effective method for the legislature to address treatment gaps. Peer recovery coaches can assist in navigating the challenging logistical barriers an individual with substance use disorder may face. One barrier that people in recovery face is seeking employment with any history of substance use on their records. Recovery coaching serves the secondary benefit of providing employment options for individuals in recovery. While services are billable to Medicaid, costs for training to become a peer recovery coach and attend continuing education are covered out of pocket for the individual and can be a barrier. These costs are relatively low ($200-$500 per person on a one-time basis), and would reap enormous returns in investment.

Prevention: **Naloxone in Schools**

Amend existing Good Samaritan Law to include school administrators in addition to harm reduction organizations, pharmacies and first responders:

Key Points:

- No cost - There is funding available for every high school in the United States to apply to access a free naloxone kit through an Adapt Pharma.
- Not a mandate or requirement. It would simply allow local control for each school district to determine whether they want to carry naloxone. It would be taking away restrictions, allowing school districts to have local determination.
- The National Association of School Nurses (NASN) developed a position statement recommending that 'schools review local and state policy on how to access naloxone and

implement its use as part of their school emergency protocol. The current standing orders for naloxone include harm reduction organizations and first responders. Because schools are not listed, Colorado Department of Public Health and Environment was unable to provide standing orders. Some school resource officers (SROs) do carry naloxone currently, but they are not at each school and are available at limited hours.

- Could be used for a staff member, parent, or SRO officer who comes in contact with opioids or fentanyl.
- Very acceptable publicly - Chris Stock described the highly positive response by school nurses at the conference he attended. Parents are asking why this doesn't already exist.

Is there a need in schools?

- A 2013 national survey on drug use and health showed that there were 2.2 million adolescents aged 12 to 17 who were current illicit drug users.
- In Colorado 1 in 7 high school students and 1 in 6 of the state's high school seniors have misused or abused prescription drugs. (Healthy Kids Colorado Survey.)
- According to the CDC, in 2015, 772 drug overdose deaths occurred in adolescents aged 15-19.

Treatment: Improving Treatment for Opioid Use Disorder in Jails and Prisons

People who leave incarceration are 129 times more likely to overdose fatally within two weeks as members of the general public. Rhode Island's efforts to provide a range of medication-assisted treatments (MAT) to all prisoners resulted in a 65% drop in such fatal overdoses, leading to a 12% drop in overdoses statewide. If Colorado could duplicate Rhode Island's success, our state could save over 120 lives per year. In order to do this, some measures the legislature could take include:

- High-quality pilot studies for both methadone and buprenorphine product maintenance in areas where there is a critical mass of incarcerated individuals already receiving MAT and ready access to treatment after incarceration. These studies should include cost-effectiveness analyses.
- Incentives for jails and their medical providers to partner with local NTPs to deliver MAT doses for current NTP clients.
- Study use of MAT in drug courts and encourage drug courts to partner with MAT providers- Indiana, New Jersey, and New York have taken this step
- Assessing long-term correctional facilities such as state prisons for induction of MAT, as this setting allows for induction, dose titrations, counseling, and thorough hand-offs prior to release

Universal consent form for behavioral health for substance use disorder

A universal consent form for behavioral health could allow for there to be improved care coordination between the different silos of care (i.e. primary, emergency, mental health, substance use). Two examples are Michigan and Minnesota. Such a consent form (although not perfect as the Minnesota form is more aimed towards mental health and the Michigan requires the exact names for information release) could help primary care and behavioral health care providers know what the other is doing. State efforts can help some but without changes in 42 CFR Part 2 it will continue to be difficult to have better care communication/coordination when it comes to substance use disorders (H.R. 3545 in US Congress would have aligned SUD records more with HIPAA but it was not included in the final opioid package, H.R. 6, from the House)

Harm Reduction: Syringe Exchange out of Emergency Departments

There are 10 syringe exchange programs in the state of Colorado. For syringe exchange programs to operate, there must be county board of health approval. Unfortunately, many board of health folks are commissioners and elected in that position. Many elected officials are not comfortable with syringe exchange programs, even though they are heavily researched and best-practice evidence-based interventions. Colorado has black tar heroin and primarily injected. Hospitals need to be able to provide syringe access, proper syringe disposal, and the supplies needed to prevent and eliminate the transmission of HIV and viral hepatitis in our most vulnerable communities.

Public syringe disposals.

Across the county, the numbers of people injecting drugs and other substances has risen dramatically over the last decade. Colorado is not immune to the challenges associated with the many layers of treatment, prevention, and harm reduction necessary to decrease the harms related to substance use. It is estimated that approximately 3 billion syringes, sharps, and lancets are disposed into municipal waste streams and recycling bins annually across the country. Communities are struggling to ensure the health and safety of children, sanitation workers, and the general public without effective disposal options for biohazardous material. Communities seek to address a number of factors responsible for improper disposal of used syringes in public areas. These public disposal containers will enhance the opportunity for the safe disposal of used sharps and reduce risk of accidental needle sticks and other public health concerns by reducing barriers to disposal options. We are asking the Opioid Interim Committee to fund 10 around the state. They cost about $4,000 plus local disposal sources (plus landowner approval) per disposal.

2018 Policy Requests from Colorado Communities

Ideas and requests were submitted by representatives from the counties of Adams, Alamosa, Arapahoe, Boulder, Chaffee, Custer, Delta, Denver, Douglas, El Paso, Fremont, Huerfano, Jefferson, La Plata, Larimer, Mesa, Montrose, Otero, Park, Pueblo, Prowers, Rio Grande, Saguache, Teller, Washington, & Weld. The ideas below do not necessarily reflect the stance of any particular agency or government organization within the aforementioned counties.

Prevention

- Enhance economic development opportunities in rural areas
- Enhance and fund spectrum of early intervention services (continuity of care across agencies and services)
- Revise naloxone access statute to specifically allow for Narcan in schools as proposed last year
- Devote more personnel for implementing prevention strategies and reducing stigma of SUDs and Narcan at the local level
    - Enhance community resiliency to prevent SUDs by providing more resources to focus on implementing risk & protective factor strategies for prevention
- Standardize toxicology and other reporting requirements for coroners to attain better data
    - Require some level of medical training to become coroner or move to medical examiner state model

Treatment

- Improve emergency room connections to treatment services. Implement universal consent form concept from Minnesota (using concept from *SB18-153* prior to amendments).
- Improve accountability, transparency, and quality of care provided by MSOs and SUD treatment centers
  - Place an ombudsman or patient care advocate in all SUD treatment programs to handle patient complaints and cases of negligence (similar to long-term care facilities and Veteran's Affairs' patient care advocates)
  - Implement Score Report Cards for SUD treatment facilities similar to hospital composite safety scores (Mark et al, 2018)
  - Require oversight and/or watchdog organizations to supervise social detox facilities – require clearly-stated parameters of what services are and are not provided by detox or treatment facilities and how they are advertised to the public
  - Convene a committee to review MSOs and consider restructuring of system
- Create full continuum of care to include more withdrawal management centers, SUD inpatient/residential facilities, community crisis living rooms, and respite options
  - Lack of funding available to create treatment centers
  - Inpatient treatment is particularly lacking for youth
  - Decrease regulatory barriers for creating a detox facility
- Increase number of spokes in MAT hub & spoke model (requests in urban and rural counties)
- Provide support to prescribers who want to do home-inductions for buprenorphine
- Create equitable reimbursement policies between rural and front range providers
  - Lack of competitive reimbursement for rural providers compared to metro providers, which leads to providers leaving rural areas to work on the front range after becoming fully licensed
- "Level playing field between rural and metro areas. Rural providers can't pay enough in salaries to compete with front-range providers. So metro areas have opportunity to recruit CAC's from rural areas because they have higher reimbursement rate and more funding"
- Lack of medical providers in rural areas with proper certification to allow for Medicaid billing by behavioral health providers
  - Medicaid requirements on who can supervise billable services is too strict
- Require continued medical education on substance use disorders for all healthcare professionals in order to renew certifications/licensures in CO
  - Target dentists
- Increase number of behavioral health providers (social work, case management, counseling)
  - BH providers need incentives to practice in rural areas – loan repayment only requires 3 years, which leads to constant turnover
- Expand preceptor tax credit to apply to behavioral health clinicians
- Offer incentives to employers who offer "wellness programs" to assist with burnout and turnover
- Expand housing program for medical and dental students via AHEC to apply to behavioral health students
- Increase number of CAC and LAC clinicians
  - Offer flexibility in caseloads and part-time work options
  - Offer incentives to employers for employing BH professionals that work part time
  - Bring continuing education for behavioral health professionals into rural areas so they don't have to travel to front range and reimburse them for lost productivity/billable hours
- Implement a program similar to IT-MATTRS for behavioral health specialists
- Give grants for rural providers to go to state-level conferences

- Loosen requirements for CAC II and III certification unless there is opportunity for reimbursement to the providers and people earning certification – eliminate Master's degree requirement for CACIII
- Loosen requirements for LACs/CACs who move from another state. Current process requires redundant training and supervision hours

- Create a standardized assessment to assist with proper placement of patients and expand access to tool at local level
  - Improve education on ASAM Levels of Care and existing SUD screening/assessment tools available

Criminal Justice

- Increase access to MAT in jails
  - Increase # of MAT providers who are serving criminal justice populations while they are incarcerated
  - Provide funding source for MAT not just from JBBS
- Standardize treatment options for MAT across all jails in state – ensure that all individuals can initiate MAT upon entry and continue it upon release
  - Allow inmates to choose their MAT treatment
- Provide telemedicine options/expansion for jails and drug courts
- Create drug court for 15th judicial district
- Re-introduce SB18-263 (mental health/criminal justice bill)
- Evaluate and revamp court-ordered detox programs
- Mandate Narcan distribution to any individual leaving jail

Recovery

- Increase subsidies for training and retention of peer recovery specialists in underserved areas
- Place peer support into emergency departments and hospitals and ask them to assist in reporting on overdose data (currently hospitals don't get overdose data until 90 days after it occurs)
- Identify barriers for individuals in recovery who have previous criminal convictions that make it more difficult for them to sustain long-term recovery
  - Look at social determinants of health (eligibility for employment, housing, education/literacy programs, transportation, federal/state assistance programs, financial assistance/loans, entrance into behavioral health workforce, etc)
  - Give tax incentives for businesses to hire people in recovery
- Peer recovery specialists to assist with the continuum of care and hired through local agencies or treatment providers.
  - Use peer specialists who work in the community to meet those with a substance use disorder and link them to treatment and follow up on overdoses. Also place peer specialists at treatment centers to provide warm hand off to recovery groups, housing, assist with job skills, etc.
  - Give warm handoffs from emergency dept. to treatment and from treatment to Sober Living Homes, recovery groups, etc.

PDMP

- Allow for the addition of tracking other medications (currently only schedule 2 and 3) for emerging drugs of abuse (e.g., gabapentin) and antidotes (naloxone)
- Add methadone used for SUD treatment to PDMP
- Allow the PDMP to include hospitalizations for overdose, integration of justice department records and a mechanism to contact providers about patient OD deaths (Doctor et al, 2018)

- Add patient race/ethnicity (to evaluate disparities) and diagnosis for prescription controlled medications that have been dispensed
- Require mandatory PDMP use (e.g., Pennsylvania)
- Refine SB-18-022 to require all prescribers to check PDMP when writing first prescription.
    - "If a state requires prescribers to view PDMP data when first prescribing controlled substances and at intervals thereafter, unsolicited reports become unnecessary."

Harm Reduction

- Require all law enforcement officers to carry naloxone on their person while on duty
- Provide naloxone to probation and parole
- Re-introduce SB18-040 (safe use sites)
- Allow hospitals to provide syringe access services
    - Explore AHECs or other places that board of health can't control to provide SAPs
- Increase state support for SAPs – they are an entry point to treatment but don't have the funding to hire staff to stay open enough hours/week
- Increase naloxone supply to the general population
- Eliminate barriers to individuals who want to pursue methadone/buprenorphine treatment options without concurrent psychosocial therapy

Billing/Funding

- Provide $2.5 million to implement strategies that would alleviate impact of SUDs on a county level or to hire a staff member that could serve as backbone support to a community coalition addressing SUDs
    - "To both integrate/coordinate the full spectrum of care in opioid use disorder (from primary care through behavioral health and into substance use treatment, including methadone) and have the individual level PHI that can be shared across a "hub & spoke" model, the system requires "coordinators" (real people working to navigate the individual with OUD/SUD through the system) and secure, technology-enabled sharing of care plans and other health information necessary for partners agencies to effectively and efficiently care for the client toward the population-level outcomes. Neither of these infrastructure supports comes without funding – at least in the beginning."
    - Fund a FTE to…
- "help pull County Partnerships together: to facilitate development of a County wide Plan; provide education and cultivate partnerships at school, law enforcement, criminal justice, and community levels; develop list of treatment providers and peer recovery specialists; increase access to naloxone"
- "general capacity: planning and coalition/advisory building, gathering data, identifying priority groups and resources, determining who does what and how big this issue is in our community"
- "facilitate completion of our plan areas/activities) with our community partners since we are leading this at the local level. We don't have any adequate ongoing funding to accomplish this and are having to find funding sources to pull together to do this work, which makes it hard."
- "Support continued capacity building and agency response - currently, very few funding dollars available directly to/for counties to address the epidemic at the community level. Funding would include using evidence-based practices while collaborating with other organizations/coalitions working in the same arena"
- "Attend convening functions, relationship management, trust building, population data sharing, etc. Our convening, facilitation, data, best practices, and grant-writing on behalf of a broad collaborative isn't currently well-funded."

- "SAMHSA grants have a rigorous data component, but it often doesn't really support either practical "clinical" information or ongoing ways to assess and inform community about population level outcomes. We have to fund local data collection focused on opioid/substance use disorders that compliments the statewide/regional information aggregated and distributed by the Consortium. Supplemental funding would help us pull out OUD/SUD information from our community needs assessments"
    - A huge part of the state does not have voters supportive of mill levy as a funding mechanism, nor could they be successful with a ballot initiative like Denver – leaving them dependent on external sources generated through state-level funding.
    - Funding to implement community level campaigns to reduce the stigma associated with addiction, treatment, and recovery
    - Limited federal or state dollars available for supporting community coalitions
    - Grants funding CTC coordinators and Regional Health Connectors is time-limited
    - Give each county alternate way of getting funding to local communities directly outside of MSOs
- Provide OBH grant-writing assistance for smaller organizations who can't afford grant writers and researchers
- Create legislation that ensures accountability and equal distribution of allocations to rural and metro areas by OBH via MSOs
    - No one with a vested interest may be allowed to serve on MSO boards that allocate funding to their own organizations
    - Transparency - create open meeting rules for MSO Boards
    - Require members who have a conflict of interest to abstain from voting in funding decisions
- Address inequality in the % paid from Medicaid between mental health and substance use when billing for services
    - Change Medicaid reimbursement to bundled or integrative billing model for Substance Use & Mental Health, at least in regards to Medication Assisted Treatment
- "Current model is problematic because providers are not able to bill for wrap-around services that are so needed to support clients because they are not a billable service"

THC

- Regulate THC levels from marijuana (listed as an APHA priority)
- Regulate retailer density for marijuana dispensaries similar to limiting tobacco retailer density

Requests at the federal level:

- Track federal hospice regulations on disposal of opioids. If it fails at federal level, look to pursue at state level
- Assess challenges to medication disposal (i.e. reduce restrictions on take back at the pharmacy)